
A Critical Psychiatry Reflection on Money-Centric, Drug-Centric and Disease-Centric Mental Healthcare

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Abstract

After more than three decades of clinical work in psychiatry, I have increasingly wondered whether the centre of psychiatric practice is, in some settings, shifting—from the person who suffers toward the disease that is diagnosed, the drug that is prescribed, and the economic structures surrounding healthcare. This is not an argument against diagnosis, medication, neuroscience, or evidence-based psychiatry. It is an argument for critical psychiatry: a willingness to examine the assumptions, limits, incentives, and unintended consequences of our own profession. In clinical practice, I have encountered patients who arrive after prolonged treatment elsewhere carrying multiple diagnoses and multiple medications, sometimes with substantial treatment burden. Such observations are clinical impressions, not prevalence data, and should not be generalized without systematic study. Yet they raise an important question: are we sometimes treating the accumulated history of psychiatric labels and prescriptions rather than the person sitting before us? Psychiatric classification is clinically useful, but diagnostic categories are not identical to the complexity of human experience. A person-centred psychiatry must therefore keep biography, context, culture, relationships, meaning, narrative, patient preference, and biological vulnerability within the same clinical frame.

Keywords: Critical Psychiatry, Medicalisation, Psychiatric Diagnosis, Person-Centred Care, Psychopharmacology, Polypharmacy, Diagnostic Inflation, Shared Decision-Making, Narrative Psychiatry, India

1. The Person Behind the Diagnosis

Psychiatry has acquired an extraordinary vocabulary for describing human suffering. We have increasingly sophisticated classifications, rating scales, diagnostic interviews, neurobiological models, and pharmacological interventions. Yet the fundamental clinical encounter remains remarkably simple: a human being sits before another human being and says, “I am suffering.”

The danger begins when the professional becomes more interested in what disorder the person has than in what has happened to the person. The distinction is not trivial. A diagnostic label can organize information, facilitate communication, guide treatment, and enable research. But a diagnosis is not a biography.

A person is more than symptoms, more than a checklist, more than a neurochemical hypothesis, and certainly more than a prescription.

2. From Person-Centred to Disease-Centred Psychiatry?

My concern, based on many years of clinical observation, is that psychiatry can become disease-centred, drug-centred and, within parts of modern healthcare, increasingly shaped by financial and institutional incentives. This is not a claim about every psychiatrist or every healthcare system. It is a question about systems, practices, and professional habits.

When distress is rapidly translated into diagnosis, diagnosis into prescription, and prescription into prolonged treatment, the possibility of understanding the original human problem may become secondary. The critical question is therefore not whether diagnosis or medication should exist, but whether they have become substitutes for a fuller clinical understanding of the person.

3. When Medication Becomes the Language of Psychiatry

Psychopharmacology has transformed the treatment of many severe psychiatric disorders and remains indispensable for many patients. A critical position should therefore not be reduced to the slogan that medication is harmful. The more clinically useful questions are: When is medication necessary? When is it helpful? What are its burdens? When should it be reviewed? What alternatives exist? And what does the patient understand and prefer?

In my clinical experience, I have seen patients presenting after treatment elsewhere with several medications, repeated additions, and considerable treatment burden. These observations require systematic research before they can be generalized. Nevertheless, medication burden and polypharmacy deserve careful review because adverse effects, drug interactions, metabolic consequences, sedation, and other burdens can accumulate.

Deprescribing, when clinically appropriate and carefully monitored, is not therapeutic neglect. It can be an active form of care. The psychiatrist's responsibility is not only to start treatment, but also to ask whether the treatment still needs to continue.

4. From Emotion to Illness

Perhaps one of the most important questions for contemporary psychiatry is where we draw the boundary between emotion and disorder, distress and disease, difference and dysfunction, suffering and psychopathology.

Sadness, fear, grief, disappointment, jealousy, anger, loneliness, and anxiety are intrinsic components of human existence. They can become pathological, but they do not automatically become pathological simply because they are intense or uncomfortable.

This does not mean that depression is merely sadness or that severe mental illness is simply a normal

emotional state. It means that context matters. A bereaved person, a person experiencing unemployment, a person facing marital breakdown, and a person with a severe depressive disorder may all say, “I feel depressed,” while describing profoundly different realities.

The clinical task is therefore not to romanticize distress, nor to medicalize it reflexively, but to understand it.

5. A Necessary Distinction: Emotion, Illusion and Delusion

The proposition that psychiatry may be moving “from emotion to illness” requires conceptual precision. An ordinary emotion does not simply evolve into a psychiatric disorder because it becomes stronger. Likewise, an illusion is not simply a mild form of a delusion.

An illusion is generally a misperception of an actual external stimulus, whereas a delusion is a pathological belief characterized by abnormal conviction and impaired reality testing. These distinctions matter clinically.

The broader critical question remains important: could the boundaries of pathology sometimes expand faster than our understanding of context and human variation? Evidence on diagnostic inflation is mixed, and criticism of psychiatric classification should itself remain evidence-based.

6. The Chemical-Imbalance Story

Critical psychiatry has also challenged overly simple biological explanations. The serotonin hypothesis of depression is an instructive example. Recent evidence has questioned the idea that depression can be adequately explained as a simple deficiency of serotonin.

This should not be converted into the opposite claim that biology is irrelevant or that antidepressants cannot help. Treatment efficacy and explanatory theory are different questions. A treatment can benefit some patients even when a simplified explanatory model later proves inadequate.

The lesson is epistemic humility. The brain matters. The body matters. The environment matters. Relationships matter. Culture matters. Meaning matters. And the person’s own account of suffering matters.

7. Psychiatry Has Become Smaller by Breaking It into Miniatures

Another concern is the fragmentation of psychiatry. We have increasingly specialized discussions around individual symptoms, disorders, molecules, rating scales, and techniques. Public mental-health education can be valuable, but psychiatry risks becoming intellectually fragmented when every human experience is discussed only through a miniature diagnostic lens.

Psychiatry is larger than its classifications. It encompasses consciousness, emotion, cognition, development, trauma, relationships, culture, society, philosophy, biology, spirituality, meaning, and the lived experience of being human.

Critical psychiatry therefore asks psychiatry to recover its intellectual breadth.

8. What Has Happened to Listening?

Perhaps the most underused psychiatric intervention is the oldest: listening. Not listening merely to collect symptoms. Not listening while mentally preparing the prescription. Not listening only to identify a diagnostic category. But listening to understand:

- What happened?
- What does it mean to this person?

- What has changed in their life?
- What are they afraid of?
- What have they lost?
- What do they hope for?
- What relationships sustain them?
- What kind of help do they actually want?

Narrative approaches to psychiatry emphasize the importance of personal meaning, identity, context, and the lived experience of illness and recovery. Listening, in this sense, is not simply courtesy. It is clinical work.

9. Critical Psychiatry Is Not Anti-Psychiatry

This distinction is essential. Critical psychiatry should not mean abandoning medicine. It means critically examining medicine.

It does not require rejecting diagnosis, pharmacology, neuroscience, psychotherapy, hospitalization, or evidence-based treatment. Instead, it challenges reductionism—the assumption that one explanatory model can adequately contain the whole of human suffering.

A mature psychiatrist does not have to choose between neuroscience and humanity. It can use neuroscience without reducing the human being to the brain, and it can value psychological and social understanding without rejecting biology.

10. The Person Must Return to the Centre

One practical alternative to disease-centred psychiatry is shared decision-making. Patients should, where possible, be involved in decisions concerning treatment choices, benefits, risks, alternatives, duration, and review.

The question can therefore change from “What treatment should I give this disorder?” to “What are the reasonable options for this person, and how can we decide together?”

That is not a weakening of medical responsibility. It is a more mature form of clinical responsibility.

11. Toward a Person-Centred Psychiatry

The psychiatry I envision is neither anti-drug nor anti-diagnosis. It is anti-reductionism.

- Diagnosis is a map—not the territory.
- Medication is a tool—not the identity of treatment.
- Symptoms are signals—not the whole person.
- Listening is not an optional courtesy—it is clinical work.
- Context is not background—it is part of the clinical picture.
- The patient is not a diagnosis—the diagnosis belongs to the patient.

Such a psychiatry would integrate biology with biography. It would ask not only, “What disorder does this person have?” but also, “What happened to this person?”, “What does their suffering mean to them?”, “What strengths do they possess?”, “What kind of help do they want?”, and “How much treatment is enough?”

Conclusion

After three decades of observing psychiatry, my concern is not that psychiatry has become scientific. My concern is that, at times, scientific language can become narrower than the human being it is attempting to

understand.

We should not replace biological reductionism with psychological reductionism, nor medicalisation with romanticism. We need integration.

The future of psychiatry may depend not simply on discovering another molecule, another diagnostic category, or another technological intervention. It may also depend on rediscovering something much older: the person.

A psychiatry that can diagnose without reducing, prescribe without reflexive overprescribing, classify without imprisoning the person inside a label, and listen without prematurely converting suffering into disease may become a more humane psychiatry.

The ultimate question is not merely, “What disorder does this person have?”

It is: “Who is this person, what has happened to them, and how can we help without losing the person in the process?”

Publication Note

This manuscript is best positioned as a Perspective, Viewpoint, or Critical Reflection rather than an empirical research article. Several observations arise from long clinical experience and should be presented as clinical reflections rather than population-level findings. Claims concerning prescribing patterns, diagnostic prevalence, pharmaceutical influence, or treatment outcomes should be supported by original empirical studies or systematic reviews before publication.

References

- Bracken P, Thomas P, Timimi S, et al. Psychiatry beyond the current paradigm. *Br J Psychiatry*. 2012;201(6):430–434.
- Bracken P. Towards a hermeneutic shift in psychiatry. *World Psychiatry*. 2014;13(3):241–243.
- Chmielowska M, Zisman-Ilani Y, Saunders R, Pilling S. Trends, challenges, and priorities for shared decision making in mental health: the first umbrella review. *Int J Soc Psychiatry*. 2023;69(4):823–840.
- Fabiano F, Haslam N. Diagnostic inflation in the DSM: a meta-analysis of changes in the stringency of psychiatric diagnosis from DSM-III to DSM-5. *Clin Psychol Rev*. 2020;80:101889.
- Faden J, Citrome L. Safety and tolerability of antipsychotic polypharmacy. *CNS Drugs*. 2012.
- Horwitz AV, Wakefield JC. *The Loss of Sadness: How Psychiatry Transformed Normal Sorrow Into Depressive Disorder*. Oxford University Press; 2007.
- Huda AS. The medical model and its application in mental health. *Int Rev Psychiatry*. 2021;33(5):463–470.
- Moncrieff J, Cooper RE, Stockmann T, et al. The serotonin theory of depression: a systematic umbrella review of the evidence. *Mol Psychiatry*. 2023;28:3243–3256.
- Slade M. Implementing shared decision making in routine mental health care. *World Psychiatry*. 2017;16(2):146–153.
- Thangadurai P, Jacob KS. Medicalizing distress, ignoring public health strategies. *Indian J Psychol Med*.

2014;36(4):351–354.

World Health Organization. Clinical Descriptions and Diagnostic Requirements for ICD-11 Mental, Behavioural and Neurodevelopmental Disorders. Geneva: WHO; 2024.



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